Mass DMH Child, Youth, & Family SERVICES

Billing Guidelines
Effective July 1, 2021

Intensive Community Services Billing Guidelines

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I. OVERVIEW

These Billing Guidelines are specific to Intensive Community Services (DMH# 2021-3061-3075-3079-01) procured by the Child, Youth and Family Division (CYF) of the Massachusetts Department of Mental Health (DMH). Intensive Community Services (ICS) include a range of in home and out of home services for youth, young adults, and their families who are involved with DMH. The services are the highest level of service that CYF provides in a community-based setting. ICS provides clinically intensive treatment and outreach support to help build, strengthen, and maintain youths and young adults' connections to family, home, and community. Services are provided in a manner that is strength based, family-driven, youth guided and culturally relevant. The three types of ICS are Intensive Home Based Therapeutic Care, Therapeutic Group Care, and Young Adult Therapeutic Care.

The goal of this document is to provide guidance to Intensive Community Services providers on the steps involved in billing for ICS. It also includes a description of the steps DMH Program and Accounts Payable staff take to approve invoices and generate payments for providers. Because the process for provider billing is contingent on the specific type of ICS provided (i.e., Intensive Home Based Therapeutic Care, Therapeutic Group Care or Young Adult Therapeutic Care), the document is organized by service type. Providers should refer to the document section(s) that are relevant to the ICS contracts that they have. Additionally, the document includes two introductory sections on the ICS contract structure and general information that is applicable to all ICS billing.

These Billing Guidelines are subject to changes based on DMH internal business processes, rate regulation reviews and/or other requirements. DMH will post updated guidelines pursuant to any changes. Provider must check DMH website to ensure they are using the most recent version.

The sections of the document are as follows (NOTE: Click on each Section to go to it in document):

- Section II: General Billing Information
- Section III: Intensive Community Services Contract Structure
- <u>Section IV: Intensive Home-Based Therapeutic Care Billing & Young Adult Therapeutic Care</u>
 <u>Outreach</u>
- Section V: Therapeutic Group Care Billing
- Section VI: Young Adult Therapeutic Care Billing
- Section VII: Add-On Rates Billing
- Section VIII: Documentation Requirements



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- Section IX: Definitions Related to Billing Procedures
- Section X: Appendices

II. GENERAL BILLING INFORMATION:

All ICS providers are required to use the Enterprise Invoice Management System (EIM) for billing DMH monthly for Intensive Community Services. EIM is accessed through the Executive Office of Health and Human Services (EOHHS) Virtual Gateway. First time users of EIM must contact EOHHS Virtual Gateway Business Operations (VGBO) Services to become an authorized user and to be trained on how to use its billing functionality required when billing DMH. Please use the following link: https://www.mass.gov/topics/virtual-gateway.

This link provides access to Job Aids for EIM: https://www.mass.gov/service-details/eimesm-training-and-user-materials.

All billing issues or problems should be addressed to the DMH POS Accounts Payable division at the following email address: BBhsposinvoices@MassMail.State.MA.US.

Invoice Due Date: ICS providers are required to complete and submit billing information for each month by the **10**th **day of the subsequent month.** This includes submitting invoices through EIM and the required supporting documentation, if any, outside of EIM. See **Appendix A-Required Supporting Documentation for ICS Billing** for flex funds in the Intensive Home-Based Therapeutic Care (IHBTC) service.

Rates: The Intensive Community Services reimbursement rates are regulated by the Executive Office of Health and Human Services as required by Chapter 257 of the Acts of 2008. The rates are set forth in the Payments for Youth Intermediate-Term Stabilization Services regulation, 101 CMR 413.00. This regulation can be found at http://www.mass.gov/eohhs. The rates are subject to periodic review as specified in M.G.L. c 118E, §13D. Below are the current rates as of July 1, 2021.

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DMH Intensive Community Services Rates					
Program	Rate	Unit			
Intensive Home Based Therapeutic Care	\$142.56	per day per enrolled youth			
Therapeutic Group Care - 6 beds	\$69,146	monthly program rate			
Therapeutic Group Care - 9 beds	\$95,731	monthly program rate			
Therapeutic Group Care - 12 beds	\$119,954	monthly program rate			
Young Adult Therapeutic Care - Outreach	\$51.31	per day per enrolled youth			
Young Adult Therapeutic Care - Staffed Apartments	\$71,646	monthly program rate			
Young Adult Therapeutic Care – Single Staffed Apartments	\$11,941	monthly single apt			
Young Adult Therapeutic Care - Supported Apartments	\$5,260	monthly single apt			
Young Adult Therapeutic Care - Supported Apartments Hold	\$61.20	daily rate			

III. INTENSIVE COMMUNITY SERVICES CONTRACT STRUCTURE

The ICS contracts are competitive bids with two types of rate structures. Contracts for Therapeutic Group Care, Young Adult Therapeutic Care (YATC) – Staffed Apartments, and YATC- Supported Apartments are billed using accommodation rates. The providers are paid the full rate whether or not all the service beds or apartments are filled. For Therapeutic Group Care and Young Adult Therapeutic Care (YATC) – Staffed Apartments contracts, the accommodation rate is based on one month of program services. For YATC-Supported Apartments contracts, the accommodation rate is based on one month of services per Supported Apartment covered by the applicable contract. Contracts for Intensive Home Based Therapeutic Care and Young Adult Therapeutic Care – Outreach services are billed using unit rates. They are billed on a daily slot rate per enrolled youth.



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The EIM Billing approach varies according to the different services and rate structures.

For contracts for Therapeutic Group Care and YATC-Staffed Apartments and Supported Apartments services providers bill using an EIM Accommodation Rate (AR) Invoice with a Service Delivery Report. For contracts for Intensive Home Based Therapeutic Care and YATC-Outreach services, providers bill using an EIM Unit Rate Service Delivery Report (SDR), and, if applicable, a separate Accommodation Rate Invoice for Flexible Funds. (Flexible Funds are applicable to Intensive Home Based Therapeutic Care only).

For EIM billing purposes, the 4-digit suffix (last digit corresponds to the contract number) in a provider's MMARS Contract Doc ID is used to differentiate between a provider's ICS contracts:

- Intensive Home Based Therapeutic Care Contract Doc ID 4-digit suffix: IHB#
- Therapeutic Group Care Contract Doc ID 4-digit: TGC#
- Young Adult Therapeutic Care: Staffed/Supported/Outreach Contract Doc ID 4-digit: YAT#

The following table includes the activity codes and the billing approach for the different ICS services and rate structures.

Intensive Community Services Contracts	Activity	Billing in EIM
	Codes	
Intensive Home Based Therapeutic Care	3073	Unit Rate/Service Delivery Report Invoice
Intensive Home Based Therapeutic Care Flexible Funding	3073	Accommodation Rate Invoice
Therapeutic Group Care	3072	
Young Adult Therapeutic Care - Staffed Apartment	3064	Accommodation Rate Invoice/Service
Young Adult Therapeutic Care – Single Staffed Apartment	3064	Delivery Report
Young Adult Therapeutic Care - Supported Apartment	3064	
Young Adult Therapeutic Care - Outreach	3064	Unit Rate/Service Delivery Report Invoice



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IV. INTENSIVE HOME-BASED THERAPEUTIC CARE BILLING - Activity Code 3073 AND YOUNG ADULT THERAPEUTIC CARE - OUTREACH – Activity Code 3064

This section describes the allowable billable activities and the billing procedures for ICS providers providing Intensive Home-Based Therapeutic Care (IHBTC) services or Young Adult Therapeutic Care - Outreach (YAOR) services.

- A. Unit of Service: The unit of service for IHBTC and YAOR services is per day per enrolled youth.
- B. Rate: IHBTC and YAOR services are billed using the daily rates identified in the rates table in Section II above.
- C. Service Code and Attendance Codes: The following codes are to be used when completing the EIM Unit Rate Service Delivery Report (SDR) for an IHBTC or YAOR contract:
 - Service Code for Intensive Home Based: ICSIHB Attendance Codes:
 - E=Enrolled
 - ER=Enrolled with Rehab Day
 - H=Enrolled but in Hospital or CBAT
 - **2.** Service Code for Young Adult Therapeutic Outreach: ICSYAOR Attendance Codes:
 - E=Enrolled
 - ER=Enrolled with Rehab Day
 - H=Enrolled but in Hospital or CBAT
- D. Submitting IHBTC/YAOR Invoice-Service Delivery Report:

An ICS provider must bill for IHBTC/YAOR services using an SDR. Every youth enrolled with an ICS provider under an IHBTC/YAOR contract will be listed on the contract SDR. DMH will generate an electronic data feed of youth enrollments from MHIS to EIM to pre-populate the SDR for each IHBTC/YAOR contract. The SDR will include a monthly calendar for <u>each</u> youth enrolled in the



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IHBTC/YAOR contract at any time during the month. The calendars will contain the names and Agency Enrollment IDs (MHIS Account Numbers) for each enrolled youth.

For each youth on the SDR, the provider must select the applicable service code and one of the 3 Attendance Codes listed in Section C above. See detailed instructions below. **Note: EIM** does not permit the reporting of service delivery before a youth's enrollment date or after the youth's disenrollment date.

- 1. Enter SDR Service Code: For each youth included on an SDR, the ICS provider must select the applicable Service Code (see above for service codes). See the Job Aid on EIM SDR billing for details: https://www.mass.gov/service-details/eimesm-training-and-user-materials.
- **2. Enter SDR Service Attendance Codes:** For each Day a youth is enrolled with ICS provider, the provider must indicate if the service received was a Rehabilitative Intervention or not or whether the youth was in a hospital or CBAT by entering the appropriate <u>Attendance</u> Code:
 - E=Enrolled
 - ER=Enrolled with Rehab Day
 - H=Enrolled but in Hospital or CBAT
- **3. Release and Authorize SDR**: After completing the SDR for each DMH client that was enrolled during the month, the provider <u>must</u> Release and Authorize the SDR in EIM.
- E. Submitting Supporting Documentation: Refer to Appendix A-Required Supporting Documentation for Intensive Community Services Billing for supporting documentation required at the time of billing.
- F. Approving IHBTC /YAOR SDR:
 - 1. Within five (5) business days of receipt of the SDR in EIM and with an EIM status of *Authorized*, DMH Accounts Payable (AP) staff will save the original SDR to the applicable payment file in the contract folder located on the DMH common drive. DMH AP staff will then notify the respective Program Approver to conduct their review and approve/deny all or part of the SDR.
 - 2. If the Program Approver determines the SDR to be accurate, they will approve the SDR in EIM. The approved SDR will run overnight in EIM and create a Payment Request document (PRC) on the next business day.



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- 3. If the Program Approver determines that the SDR is not accurate, they will deny one or more of the youth's record(s). If this is done, they will contact the provider and explain the reason(s) for the denial. If appropriate (e.g., adding services for an enrolled youth, correcting service days for enrolled youth, etc.), the provider must submit a corrected SDR for that youth(s) on a Supplemental SDR as described in IV.G below. The Program Approver will approve the accurate youth records if any.
- **4.** An SDR will be processed as *Approved* by DMH AP staff only if the total Units of Service reported when added to the previously number of Units of Service billed for the fiscal year are less than or equal to the maximum number of Units of Service that can be billed for the applicable Contract for that fiscal year.
- **5.** Once a SDR is *Approved*, the DMH AP staff will complete the "*Program Approval*" of the PRC in EIM. This must be done prior to the "*Accounting Approval*."
- **6.** The DMH AP staff will review the PRC and ensure that it is referencing the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the *Accounting Approval* for the PRC.
- 7. All PRC documents that have both levels of Accounts Payable approval completed (i.e., Program and Accounting Approval) will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will then generate payments for PRCs.

G. Submitting Supplemental Billing - IHBTC /YAOR SDR

- **1.** Supplemental Billing is any billing submitted by a provider for a month that is submitted subsequent to the initial bill for that month. Supplemental Billing can be either for a positive or negative adjustment.
- 2. If there was an omission of a youth(s) or day(s) of service from the original SDR, EIM allows the provider to enter services by accessing the enrollment link for the youth. The provider completes the required information as described above. The DMH Program Approver and the DMH AP staff process the documents as outlined in Section IV.F above.
- 3. If the number of units were over-reported in a previous month for one or more youth, this needs to be corrected by accessing the applicable youth's enrollment link and voiding the entire previously submitted youth's record for each month that needs to be corrected. If the youth received units of service in a month that was voided, a supplemental SDR for that month(s) must be submitted with the correct service unit information as described in steps G(1) and G(2) above.



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- **4.** Upon receipt of a negative Supplemental SDR in EIM, the SDR will be processed in accordance with IV.F above, except that the approved Supplemental SDR will create an Encumbrance Correction (CEC) document the following business day. If the Supplemental SDR is not accurate, it will be denied by the Program Approver, and they will alert the provider that another corrected SDR must be submitted.
- **5.** DMH AP staff will complete the Program Approval of the CEC document in EIM. This must be done prior to Accounting Approval and must also be done prior to approval of any PRCs for the same contract.
- **6.** Once Program Approval is completed for the CEC, the DMH AP staff will review the CEC and apply the Accounting Approval for the CEC document.
- 7. The following business day all CEC documents that have both levels of approval completed will appear in the PRC/CEC Batch Report. The Batch Header information will be entered by appropriate DMH AP staff into MMARS and will process overnight and activate the credit memo process that will offset future payments until the full amount of the CEC has been recouped.

H. Billing for IHBTC Flexible Funding-Accommodation Rate Invoice

- 1. A provider who is allocated Flexible Funding for youth receiving IHBTC services must bill for them using a separate Accommodation Rate (AR) Invoice using the procedures described below. ICS providers who are allocated Flexible Funding in their IHBTC contract are required to submit Flexible Funding Monthly Expense information through the Virtual Gateway Provider Portal (for both initial AR invoice and any supplemental AR invoicing). See Appendix B:
 - Procedures for the Use of Intensive Community Services Flexible Funding.
- **2. Units of Service:** A unit of service for Flexible Funding is the total monthly expenditures made on behalf of all Youth/Family within the billable month.
- 3. Service Codes:
 - a. Accommodation Rate Description for Flexible Funding = FF
- 4. Rates:
 - a. The daily rate in EIM for Flex Funding = \$1.00 (Note: It is not an actual daily rate. A provider will be paid the amount equal to the total amount of expenditures made during the month for youth and families in the contract.)

5. AR Invoicing and Approval Steps:

- a. The provider creates an AR Invoice and enters the total of all Flexible Funding expenditures for all youth for the billable month on the AR line labeled "**FF**".
- b. The provider then completes a "Release and Authorize" of the invoice.



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- c. Once the AR Invoice is in 'Authorized Status', the EIM system will automatically create a PRC (Payment Request Document) overnight. Within five (5) business days of receipt of the AR Invoice in EIM and with an EIM status of PRC Ready, the DMH Accounts Payable (AP) staff will then notify the respective DMH Program Approver for that contract.
- d. The Program Approver will then review the AR Invoice and supporting flex funds documentation that is submitted to appropriate DMH Child Youth and Family Area Director.

 After reviewing these documents, the Program Approver will approve/deny the associated PRC
- e. If approved by the Program Approval, DMH AP staff will review the PRC and ensure that it is referencing the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the Accounting Approval of the PRC.
- f. All PRC documents that have both levels of approval completed will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs and recoups CECs.
- g. If the Program Approver **denies** the PRC, they will contact the provider to explain the reason for the denial (e.g., proper authorization is not obtained, expenditure(s) is not consistent with Appendix B, etc.) and have the provider submit a Supplemental AR Invoice with a new total and a corrected flex fund report for the moth as required by Appendix B. The Supplemental AR invoice will then be processed as outlined in steps 5(d)-5(f) above. If the error is detected after the original invoice is Approved and Paid, the provider will follow the steps outlined below for Supplemental Billing.

6. Submitting Supplemental Billing for Flexible Funding-Accommodation Rate Invoice:

- a. Supplemental Billing is any billing submitted by a provider for a month subsequent to the initial bill for that month. Supplemental billing can be either for a positive or negative adjustment.
- b. To submit a Supplemental Billing, a provider must select the billing module; select the ADD Accommodation Invoice button. Then select the contract from the drop-down menu.
- c. Enter an Invoice Reference Number. (This is a new number.)
- d. Enter the billing month you are trying to correct.
- e. Select the Accommodation Rate Supplemental radio button and click Save.
- f. Enter <u>Units</u>. This value should be the difference between the original and correct number of units for the billing month. For example, if a provider originally billed for 1,000 units and it should have been 800 units, you would enter -200 in the Units field.
- g. Save the invoice and a message will display "Invoice Updated Successfully".



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h. Release and Authorize the Invoice.

V. THERAPEUTIC GROUP CARE BILLING - Activity Code 3072

This section describes the billing procedures for Therapeutic Group Care contracts.

- **A.** Unit of Service: A unit of service for a Therapeutic Group Care contract is One Month. The provider will bill ONE unit for each month the contract is effective.
- **B.** Accommodation Rate Description: Each provider's TGC contract will have a unique Accommodation Rate description (i.e., name) that is pre-populated in the provider's AR Invoice.
- C. Rate: The monthly rate for each TGC contract varies based on the bed capacity in the contract (i.e., 6, 9, or 12 bed capacity). DMH will program the appropriate value into EIM.
- **D.** Submitting TGC AR Invoice with a Service Delivery Report (SDR): A provider is to invoice DMH monthly for each TGC contract the provider has. The provider's TGC contract name (i.e., accommodation rate description) and monthly rate will pre-populate the provider's AR Invoice when the provider creates it in EIM.

DMH requires ICS providers to submit a Service Delivery Report every month with their Accommodation Rate Invoice. Every youth enrolled with the ICS provider for TGC services will be listed on the SDR. DMH will generate an electronic data feed of youth enrollments from MHIS to EIM to pre-populate the SDR for each TGC Contract. The SDR will include a monthly calendar for each youth enrolled in the TGC Contract at any point during the month. The calendars will contain the names and Agency Enrollment IDs (MHIS Account Numbers) for each youth enrolled with the TGC provider.

The steps for AR invoicing are as follows:

- 1. The provider creates an Accommodation Rate Invoice and enters the unit of 1 (one) into the Units field in EIM for the billing period. The provider then saves the invoice.
- **2.** After saving the invoice, the provider must add the SDR **before** Releasing and Authorizing the invoice. The provider then completes the SDR.



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3. Completing SDR: For each youth on the SDR, the provider must enter the appropriate service code, and Attendance Code listed in the instructions below. Note: EIM does not permit the reporting of service delivery before a youth's enrollment date or after the youth's disenrollment date.

Enter SDR Service Codes: For each youth included on an SDR, the TGC provider must select the corresponding Service Code (see below).

Service Description	EIM Activity Code	EIM Service Code
Therapeutic Group Care 6	3072	ICSGC6
Therapeutic Group Care 9	3072	ICSGC9
Therapeutic Group Care 12	3072	ICSGC12

Enter SDR Service Attendance Codes: For each Day a youth is enrolled in a bed with TGC provider, the Provider must indicate if the service received was a Rehabilitative Intervention or not, whether the youth was in a hospital or CBAT, or whether they were enrolled in the bed for Respite only by entering the appropriate <u>Attendance Code:</u>

- E=Enrolled
- ER=Enrolled with Rehab Day
- H=Enrolled but in Hospital or CBAT
- RP=Respite Day.
- **4.** Once all the Attendance Codes have been added, the SDR needs to be in 'Reported' status.
- 5. The Accommodation Rate Invoice can now be Released and Authorized.

E. Approving TGC AR Invoice with Service Delivery Report (SDR):

- 1. Once the AR Invoice is in 'Authorized Status', the EIM system will automatically create a PRC (Payment Request Document) overnight. Within five (5) business days of receipt of the AR Invoice in EIM and with an EIM status of PRC Ready, the DMH Accounts Payable (AP) staff will notify the respective DMH Program Approver for that contract.
- 2. The Program Approver will then review the AR Invoice as well as the SDR supporting documentation required (see D above) and approve/deny the associated PRC.
- **3.** If approved by the Program Approver, DMH AP staff will then review the PRC and ensure that it is referencing the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the Accounting Approval of the PRC.



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- **4.** All PRC documents that have both levels of approval completed (Program and Accounting Approval) will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs.
- 5. If the Program Approver denies the PRC, they will contact the provider to explain the reason for the denial and have the provider submit a Supplemental AR Invoice with the corrected information. The Supplemental AR invoice will then be processed as outlined in steps E(1) E(4) above. If the error is detected after the original invoice is Approved and Paid, the provider will follow the steps for AR supplemental billing outlined in Section V.F below.
- **F.** Submitting Supplemental Billing TGC Accommodation Rate (AR) Invoice: Supplemental Billing is any billing from a provider for a month that is submitted subsequent to the initial bill for that month. If corrections or additions to the AR SDR are needed, the provider must create a ZERO\$ Supplemental AR Invoice to submit a Supplemental AR SDR.

VI. YOUNG ADULT THERAPEUTIC CARE STAFFED OR SUPPORTIVE APARTMENTS BILLING – Activity Code 3064

This section describes the billing procedures for Young Adult Therapeutic Care-Staffed Apartments and Supported Apartments contracts. NOTE: the billing procedures for the Young Adult Therapeutic Care Outreach service are the same as those for the Intensive Home Based Therapeutic Care contracts and can be found in Section IV. above.

A. Unit of Service: A unit of service for Young Adult Therapeutic Care (YATC) Staffed Apartments contract is one month of program services (this covers all beds and apartments in the contract) and for Supported Apartments it is one month per supported apartment covered by the contract. Thus, for Staffed Apartment contracts, the number of units billed will always be one, unless the contract is amended to add another bed, in which case in addition to the one monthly program unit; the provider would also bill for one (or more) YATC Staffed Apartment single Apartment unit(s) of service for the bed or beds that were added by amendment to the contract (see below for more information on this). For YATC Supported Apartments, the number of units billed will vary by contract depending on the number of Supported Apartments covered by the contract.



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- **B.** Accommodation Rate Description: Each Provider's YATC Staffed or Supported Apartment contract will have a unique Accommodation Rate description (i.e., name) that is pre-populated in the provider's AR Invoice. These names will be the same as their MHIS Program Codes.
- C. Rate: The monthly rate for Staffed or Supported Apartment YATC contracts varies based on whether it is a Staffed or a Supported Apartment contract. DMH will program the appropriate value for each contract into EIM.
- **D.** Submitting YATC Staffed or Supported Apartment AR Invoice with a Service Delivery Report (SDR): A provider must invoice DMH monthly for each YATC Staffed or Supported Apartment contract they have. The provider's YATC Staffed or Supported Apartment contract name (i.e., accommodation rate description) and monthly rate will pre-populate the AR Invoice when the provider creates it in EIM.

DMH requires providers to submit a Service Delivery Report with their Accommodation Rate Invoices. Every youth enrolled with an ICS provider for YATC Staffed or Supported Apartment services under the applicable contract will be listed on the SDR. DMH will generate an electronic data feed of youth enrollments from MHIS to EIM to pre-populate the SDR for each YATC Staffed or Supported Apartment contract. The SDR will include a monthly calendar for each youth enrolled in an YATC Staffed or Supported Apartment Contract at any time during the month. The calendars will contain the names and Agency Enrollment IDs (MHIS Account Numbers) for each youth enrolled with the YATC provider.

The steps for AR invoicing are as follows:

- 1. The provider creates an Accommodation Rate Invoice and for YATC Staffed Apartments the provider enters the unit of 1 (one) into the Units field in EIM for the billing period. For YATC Supported Apartments, the Provider enters for the number of units the number of supported apartments covered by the contract. The provider then saves the invoice.
- **2.** After saving the invoice, add the SDR **before** Releasing and Authorizing the invoice. The provider then completes an Accommodation Rate Service Delivery Report (SDR).
 - Completing SDR: For each youth on the SDR, a provider must enter the appropriate YATC service code and appropriate Attendance Code listed in the instructions below. Note: EIM does not permit the reporting of service delivery before a youth's enrollment date or after the youth's disenrollment date.



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- Enter SDR Service Codes:
 - Young Adult Staffed Program = ICSYAST
 - Young Adult Supported Program = ICSYASU
 - Young Adult Single Staffed Apartment = ICSYASTSA (See note below)
- Enter SDR Attendance Codes:
 - E=Enrolled
 - R=Enrolled with Rehab Day
 - H=Enrolled but in hospital or CBAT
 - RP=Respite Day
- 3. Once all the Attendance Codes has been added, the SDR needs to be "Reported" status.
- 4. The Accommodation Rate Invoice can now be Released and Authorized.

Note on YATC Single Staffed Apartments: This rate was developed to give DMH the ability to add additional beds to an existing Staffed Apartment contract. The rate is the cost of adding an additional bed. The addition of a bed would require a contract amendment. If a bed is added, the provider would need to submit monthly a separate AR Invoice for the Single Staff Apartment Accommodation Rate and would also need to submit an AR-SDR with it as directed above.

Note on YATC Supported Apartments Hold: This rate was developed to allow DMH to obtain or maintain a Supported Apartment for a period when the Apartment will not be occupied by a youth and therefore, staff is not needed. It is anticipated that the hold period will be for one or more months. At this time, DMH does not expect to use this rate but may in the future. If used, it will be reflected in the applicable contract, either at the time of execution or by amendment. If purchased from a provider, the provider would need to submit monthly a separate AR Invoice for the Hold. An AR-SDR would not be necessary

E. Approving YATC AR Invoice with Service Delivery Report (SDR):

- 1. Once the AR Invoice is in 'Authorized Status', the EIM system will automatically create a PRC (Payment Request Document) overnight. Within five (5) business days of receipt of the AR Invoice in EIM and with an EIM status of PRC Ready, the DMH Accounts Payable (AP) staff will notify the respective DMH Program Approver for that contract.
- 2. The Program Approver will then review the AR Invoice as well as the SDR supporting documentation required (see Section VI.D above) and approve/deny the associated PRC.
- **3.** If approved by the Program Approver, DMH AP staff will then review the PRC and ensure that it is referencing the correct contract lines and that the payment amount is apportioned to the correct funding sources. They then apply the Accounting Approval of the PRC.



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- **4.** All PRC documents that have both levels of approval completed (Program and Accounting Approval) will appear in the PRC/CEC Batch Report on the following day. The Batch Header information will be entered by appropriate DMH AP staff into MMARS. MMARS will generate payments for PRCs.
- 5. If the Program Approver denies the PRC, they will contact the provider to explain the reason for the denial and have the provider submit a Supplemental AR Invoice with the corrected information. The Supplemental AR invoice will then be processed as outlined in steps E(1) E(4) above. If the error is detected after the original invoice is Approved and Paid, the provider will follow the steps for AR supplemental billing outlined in Section VI.F below.
- **F.** Submitting Supplemental Billing YATC Accommodation Rate (AR) Invoice with Service Delivery Report (SDR): Supplemental Billing is any billing from a provider for a month that is submitted subsequent to the initial bill for that month. If corrections or additions to the SDR are needed, the provider must create a ZERO\$ Supplemental AR Invoice to submit a Supplemental SDR.

VII. ADD-ON RATE BILLING

- A. A provider desiring to use an Add-On rate, must submit an Add-On Request Form to the applicable Area Office for approval. (See Attachment C.)
- B. If approved, the provider providing the Add-On services in a month must submit a completed Add-On Services Monthly invoice Log (See Attachment D) in the Excel format to the following address by the 10th day of the subsequent month: BBhsposinvoices@MassMail.State.MA.US.
- C. A separate Log must be filed for each contract the provider is seeking payment for the delivery of an Add-On Service. Also, separate logs must be completed for each contract if submitting both client based and program based Add-On services within the same contract.
- D. The Monthly Log will list all Add-On services provided by the provider in a month for each contract.
- E. For each youth/program listed, the provider will complete the following fields:

<u>Field</u> <u>Description</u>

Client or Program Name The Client's first and last name or Program Name.



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DMH Account # The MHIS Account # that is unique to the client enrollment if

client based add on

Service Code The applicable Service Code that applies to the Add-On Service.

Date of Service The date that the Add-On Service was provided.

#Units The number of Units of Add-On Service provided that day.

Rate The applicable rate for the Add-On Service from the Rate Table.

(See rate table below)

Total Cost The number of Units multiplied by the rate.

- F. Once completed, the Log must be signed and dated by the contractor, and forwarded to the DMH Accounts Payable staff at the address listed in B above. The Log must be sent using the DMH secure email function.
- G. The DMH Accounts Payable staff will forward to the DMH Program Approver for approval. If approved, the DMH Accounts Payable staff will process the invoice in MMARS for payment to the provider. If not approved, the DMH Program Approver will contact provider for a corrected invoice. Once it is corrected and approved, it will be processed in MMARS for payment.

Add-on Rates						
Service Code	Position	1.0 FTE	0.75 FTE	0.50 FTE	0.25 FTE	HOURLY
DC	Direct Care	\$3,305	\$2,479	\$1,653	\$826	\$20.32
CAN	Certified Nursing Assistant	\$3,316	\$2,487	\$1,658	\$829	\$20.40
DCIII	Direct Care III	\$4,262	\$3,196	\$2,131	\$1,065	\$26.20
OT	Occupational Therapist	\$8,067	\$6,051	\$4,034	\$2,017	\$55.04
ОТА	Occupational Therapist Assistant	\$6,385	\$4,788	\$3,192	\$1,596	\$43.56
MA	Case Manager, Social Worker, Clinician (MA level-not Independent Licensed)	\$5,406	\$4,054	\$2,703	\$1,351	\$36.88



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LPN	LPN	\$5,897	\$4,423	\$2,948	\$1,474	\$40.20
RN	Registered Nurse	\$8,916	\$6,687	\$4,458	\$2,229	\$60.80
MA-Lic	Clinician w/Independent License	\$6,253	\$4,690	\$3,127	\$1,563	\$42.64
SW-BA	Social / Caseworker (BA Level)	\$4,513	\$3,385	\$2,257	\$1,128	\$30.76
APRN	Nurse Practitioner / APRN					\$83.56
PHD	Psychologist / Psychiatrist (PhD)					\$136.75
FOR	Forensic Psychiatrist					\$159.50

VIII. DOCUMENTATION

All billing (Invoices) and supporting documentation (SDRs) must be retained by both the provider and DMH for a minimum period of 6 years beginning on the first day after the final payment under a contract, or such longer period as is necessary for the resolution of any mitigation, claim, negotiation, audit, or other inquiry involving a contract (Paragraph 7 of the Commonwealth Terms and Conditions for Human and Social Services). Records may be retained electronically in PDF Format or by hard copy.

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IX. DEFINITIONS RELATED TO BILLING PROCEDURES

Accommodation Rate (AR) Invoice - The mechanism used by providers to bill DMH for all costs related to the service purchased for which an accommodation has been established...

Activity – The Activity Code is a 4 digit number used in MMARS (Commonwealth accounting system) and EIM that identifies the service. The Intensive Community Services activity codes are 3073 for Intensive Home Based services, 3072 for Therapeutic Group Care services, and 3064 for Young Adult Therapeutic Group Care services.

Enterprise Invoice Management System (EIM) – The web based invoice system that automates the transmission of client information and service data that Commonwealth purchase -of-service providers transmit to agencies from which they seek reimbursement for the provision of services.

Flexible Funding- Funds authorized by DMH that are used to purchase goods and services that maximize the benefit a youth derives from mental health interventions and activities delivered through DMH Services. Flexible Funding is intended to promote youth and family permanency, well-being, and self-efficacy.

Mental Health Information System (MHIS) – DMH's electronic medical record system.

MHIS Account Number (Account Number) – The number MHIS generates when a client is enrolled into a provider's ICS Service. The number is unique to the enrollment. In EIM, the MHIS Account Number appears as the Agency Enrollment ID.

Provider Portal (DMHPP) – The Virtual Gateway's secure website used by providers to upload ICS data in XML format to the Department of Mental Health.

Rehabilitative Encounter – A clinical intervention that is delivered in accordance with Federal claiming requirements for Medicaid Rehabilitation Option (Rehab Option) and as outlined in DMH Rehab Option guidance documentation. Telephonic contacts and collateral activities, including work completed to develop, update and/or revise and assessment and or treatment plan are rehabilitative encounters when provided as outlined in DMH Rehab Option guidance documented.

Service Delivery Report (SDR) – An electronic document accessed through the Enterprise Invoice Management System (EIM) that providers use to report to DMH each day a client is enrolled in ICS

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and how many hours of service they received. The SDR is populated using enrollment information maintained with MHIS. The SDR is used to generate a payment and/or monitor service utilization.

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X. APPENDICIES

Appendix A- Required Supporting Documentation for ICS IHBTC Billing

ICS IHBTC Services Providers are required to submit supporting documentation to their DMH Area contacts and Procurement Managers at the same time that they bill for ICS Services. The due date for submitting supporting documentation is the same as that for billing: **the 10**th **day of the subsequent month.**

• Flexible Funds Monthly Expense Reports: See Appendix B for the specific information required in the reports. ICS Providers who are allocated Flexible Funding in their IHBTC contract are required to submit Flexible Funding Monthly Expense information through the Virtual Gateway Provider Portal.

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Appendix B- PROCEDURES FOR THE USE OF DMH FLEXIBLE FUNDS FOR INTENSIVE HOME BASED THERAPEUTIC CARE SERVICE

I. Background and Purpose

DMH Flexible Funds can be used to purchase goods and services that maximize the benefit a youth derives from mental health interventions and activities delivered through DMH Services. Flexible Funds are intended to promote youth and family permanency, well-being, and self-efficacy.

The following procedures specify the requirements that Providers must follow when using Flexible Funds. Flexible Funds must be expended in accordance with the se procedures.

II. Authorization for Flexible Funds

Flexible Funds are authorized at the discretion of the applicable DMH Child, Youth and Family Services Area Director (or designee). If authorized, they will be for a specified individual and/or family and purpose. In order to allow for supporting families in a timely fashion, decisions about use of flex funds for a particular youth/family does not have to be formally and individually approved if the amount is under \$500. However, it is expected that most of these decisions are being made as part of a Family Team Meeting so DMH would be part of the decision at that level. Any flex fund requests for \$500 or more would need approval from the DMH Child, Youth and Family Director or designee in the Area.

Allowable Purchases

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Flexible Funds may be used to pay for certain contingency expenses that provide direct support to youth or their families to assist with their health, welfare, well-being, and safety needs. Flexible Funds may be used for necessities that assist in transitioning or maintaining a youth in the community when the lack of those necessities would likely lead to the youth's psychiatric destabilization and/or cause undue hardship on the youth or family. Flexible Fund expenditures must be consistent with the needs and treatment plan goals of the youth and family. Flexible Fund expenses are expected to be time limited. Treatment plans should reflect plans to sustain activities (where necessary) through natural supports, other funding sources, and/or other means in anticipation of Flexible Funds ending.

Providers must demonstrate reasonable efforts to obtain the needed goods or services from other sources, such as community organizations, insurance (i.e., third-party payers), faith-based organizations, philanthropic groups, and other entities. Needed goods or services may be available from these entities in the form of direct payment for the good/service, scholarships, sliding scale fees, reduced/discounted prices and or fees; donations of gift certificates or clothing; etc.

Examples of Inappropriate Flexible Funds Expenses. Inappropriate uses of Flexible Funds include, but are not limited to:

- Program petty cash fund
- Program expenses
- Office supplies
- Staff training
- Cleaning of office space
- Mortgage payments
- Credit card payments
- Luxury items
- Ongoing contingency expenses beyond 3 months
- Program subscriptions to mental health journals or membership dues for program staff
- Expenses that do not support the youth/family goals and/or are not a direct benefit to them.

Gift certificates must either specify that they cannot be used for firearms, gambling/lottery tickets, and tobacco and alcohol products; or must be for stores, etc. that do not offer such goods.



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III. Required Documentation

The Provider is required to maintain all original documents relative to Flexible Funds for a period of six (6) years after the applicable contract has ended. This includes but is not limited to:

- **A.** Invoice/receipt from the vendor/service provider. The Provider must obtain a receipt or an invoice for each good or service purchased using Flexible Funds from the vendor which sold or provided the good or service. The receipt/invoice must indicate the name of the vendor, the vendor's address, a description of the good(s)/service(s) provided, the cost of the good(s)/service(s) and the date of purchase.
- **B.** Acknowledgement from the youth/family. For each good or service purchased for a youth/family using Flexible Funds, the Provider must obtain a signed written receipt or acknowledgement from the parent or Legally Authorized Representative (LAR) of the youth on whose behalf the good or service was purchased (or if the youth is 18 years of age with capacity, from the youth). The receipt or acknowledgement must indicate that the youth or their family received or otherwise utilized the good/service. The receipt or acknowledgement must be dated and signed.

IV. Provider Monitoring and Quality Control

- **A.** The Provider must maintain and implement written internal controls regarding the management of Flexible Funds. The controls must be designed to prevent the misuse of such Funds and to ensure compliance with these procedures.
- **B.** Checks must be made out to and endorsed by the entity providing the goods/service that is being reimbursed.
- C. Gift certificates, transportation and other types of passes/vouchers and checks written directly to staff or youth/family require stringent procedures that must be in place for their authorization and monitoring. The Provider must be able to prove that these purchases are used for authorized youth/families. To this end the following controls shall be implemented when Flexible Funds are used for (a) the purchase of gift certificates, passes and vouchers or (b) checks made directly to a staff (for reimbursement of purchase of an approved item for youth/family) or (c) checks made directly to a youth/family:
 - The purchase and distribution of these items must be documented in a log, which is to be developed and maintained by the Provider.
 - The log must document at a minimum, the following information:



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- o Identifier number for the gift certificate, pass, voucher, check
- o Purchase date of certificate/pass/voucher; or if a check, date on the check
- Dollar amount of the purchase
- o Name of the business from which the purchase was made
- Description of item (i.e., staff reimbursement for weighted blanket, T-Pass, Mobil Gas certificate)
- o Name of applicable staff, youth and parent or LAR
- Printed name and title of individual authorizing release of the certificate/pass/ voucher or check
- Date that the certificate/pass/voucher was issued to the staff, youth, or family;
 or if a check, date that check was issued to staff, youth, or family
- Date that staff/youth/family acknowledge receipt of the certificate/pass/voucher/check
- **D.** If Flexible Funds are paid directly to a Youth/family, the Provider must inform the Youth/family about potential tax implications.
- E. The Provider is responsible to review expenditures of Flexible Funds and the process by which they were expended to ensure compliance with related DMH regulations and program procedures. At a minimum, the Provider must review and reconcile the amount of Flexible Funds used for contingency expenses on a monthly basis.

V. DMH Monitoring and Quality Control

Given DMH's requirement that Flexible Funds be used appropriately, DMH for good cause can mandate that:

- A Provider immediately cease making any expenditure(s) for a specific youth/family
- A Provider immediately cease making any Flexible Fund expenditures.

The mandate may be given by a DMH Area Director or Area Director of Child, Youth and Family Services Area. It may be made verbally, but then it must be followed by written notice within one business day. "Good cause" can include situations where there exists a pattern of not submitting required receipts/invoices; a violation of Regulation, Accounting Standards, or other procedures. Should DMH exercise the right, a meeting will be convened with the Contractor to review the situation.

At a minimum on a quarterly basis, the applicable DMH Area Office(s) will review the distribution and amount of Flexible Funds used for contingency expenses within the Area.



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Additionally, at a minimum annually, the DMH Central Office will randomly review the records of Providers and DMH Area/Site Offices relating to the Flexible Funds for compliance with these procedures.

VI. Reporting

A. Monthly Expense Reporting. Every month, Providers are required to submit specific information (described below) on all Flexible Fund expenditures made during the month. This information must be submitted to the appropriate DMH Child Youth and Family Area Director in the format provided by DMH. DMH will issue the format specifications before the start of Flexible Support Services Contracts. The Monthly Expense Reporting information must be submitted at the time of invoicing and will be used to review and approve invoices. Invoices will be held until this information is received. All required information must be received before invoices will be reviewed.

The required information is as follows: For each Flexible Fund expenditure made in the month:

- Identifier number for the gift certificate, pass, voucher, check
- Purchase date of certificate/pass/voucher; or if a check, date on the check
- Name of the business from which the purchase was made
- Fund amount of the purchase
- Name of applicable youth, family member, or LAR
- ID# of youth
- Description code: This code is supplied by DMH to reflect the type of purchase made.
- **B. DMH Maintenance of Reports.** The DMH Management & Budget Department, Procurement Unit, will maintain copies of all Provider Monthly Expense Reports as part of Provider procurement files.

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Provider Name:

Section 1: Provider Information

Attachment C

Department of Mental Health

ICS ADDITIONAL SERVICES REQUEST FORM

☐ Young Adult Therapeutic Care – So☐ Intensive Home Based Therapeutic		ic Care – Outreach
Requestor's Name:	Phone #:	
Requestor's email address:		
Area Office: Western MA	Central MA	etro-Boston 🗖 Northeast
Programmatic Add-on (not tied to	o specific youth) 🔲 Individual You	th Add-on*
*Youth/Young Adult's Name:		
*Youth/Young Adult DMH ID #:		
* DMH Contact:		
ection 2: Hours of Service		
Service Period:		
Total Hours or total FTE:		
Data (bandard ETE)		
Rate: (hourly or by FTE)		
ection 3: Type of Additional Services		
Direct Care I	☐ Case Manager/Clinician (MA level,	☐ Nurse Practitioner/APRN
■ Direct Cale i	not independently licensed)	- Nurse Fractitioner/AFMN
☐ Direct Care III	☐ Case Manager/Clinician	☐ Psychologist (PhD) /Psychiatrist
a birecteatem	(Independently Licensed)	a i sychologist (i ilb)//i sychiatrist
☐ Certified Nursing Assistant	☐ Case Manger – BA level	☐ Forensic Psychiatrist
Occupational Therapist	☐ LPN	a Forensier Sychiatrist
Occupational TherapyAssistant	☐ Registered Nurse (RN)	
— Occupational merupy/33/3tane	— Registered variet (NIV)	<u> </u>
ection 4: Reason for Services (clinical,	hehavioral safety)	
control of the contro	benavioral, surety)	



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Section 5:	Description of Services (describe services, outcomes expected,	performance measures, monitoring, reporting)	
Section 6:	Approval of Services			
Name		Title	Signature	Date
				<u> </u>
1				

General Information

- All requests for additional services must have written approval **PRIOR** to start of services
- Requests are not considered approved until Additional Service Request Form is returned to the provider with signatures of the Area CYF Director or designee
- Requests should be considered short term and should include a plan for transitioning youth to work within the model structure

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Attachment D

INTENSIVE COMMUNITY SERVICES						
ADD-ON SERVICES MONTHLY LOG						
Contract Number:						
Contractor Name:			1			
Client or Program Name	DMH MHIS account # if applicable	Service Code	Date of Service	#Units	Rate	Total Cost
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
						\$ -
			TOTAL MONTHLY	COSTS		\$ -
Contractor Signature:						
5						
Date:						